Parental and Caregivers Attitudes Toward the Use of Play in Therapy for Children Impacted by Trauma

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A report submitted in partial requirement for the degree of Bachelor of Arts with Honours in Psychology at the University of Tasmania, 2017.

Words: 9383

Statement of Original Authorship

I declare that this is my own work and that to the best of my knowledge and belief it contains no material previously published or written by another person except where acknowledged and cited.

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Diane McGeachy

Acknowledgements

I extend my deep appreciation to my Supervisor Dr Kimberley Norris who was a constant rock of guidance, optimism and encouragement throughout the year. You are a source of inspiration and wisdom. To the Australian Childhood Foundation, specifically Sonya Pringle-Jones and Tracey Howard for their unwavering support and positivity. I would like to acknowledge my mentor Diana Lalor who has been a key person in supporting me to finally return to school and complete my honours. You have taught me so much about what really matters in therapy. Thank you to the parents and carers who courageously took the time to participate in this research, none of this would have been possible without you.

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Abstract

The present study investigated parents and caregiver's attitudes toward the use of play in therapy for children impacted by trauma. Parents and caregivers ($N = 73$) completed an online questionnaire that included; the Parent-child Attachment Scale, the Parenting Styles Dimensions Questionnaire, the Parental Play Beliefs Scale, the Attitudes Towards Seeking Professional Psychological Help- Short Form Scale as well as a series of sociodemographic questions and a questionnaire relating to their experience of bringing their child to therapy. Backward stepwise regression results indicated that different dimensions within each parenting style predicted whether the parent valued the use of play in therapy as well as looking at the parent's level of enjoyment interacting with their child through play. These findings indicate that certain parenting traits can be screened for when parents bring their child to therapy in order to achieve positive outcomes in the therapeutic process and to reduce early termination of therapy.

In 2007, it is estimated that between 177 000 – 666 000 Australian children suffered abuse or neglect (Taylor et al., 2008). It is estimated that one in four girls and one in five boys are sexually abused and one third of children are thought to experience physical abuse worldwide. (Anda et al., 1999; Putnam, 2003; United Nations, 2006). Childhood relational trauma is the harm caused within an interpersonal relationship that includes physical, sexual, psychological abuse, neglect or exposure to family violence (Gabowitz, Zucker & Cook, 2008). It is estimated that 80% of all childhood abuse occurs by the child's own parents, with relatives of the child accounting for another 10% (van der Kolk, 2003).

In the Adverse Childhood Experiences (ACE) study by Kaiser Permanente and the Centre for Disease Control 17, 337 adults responded to a questionnaire about adverse childhood experiences (van der Kolk, 2003). Figure 1 outlines the breakdown of adverse childhood experiences.

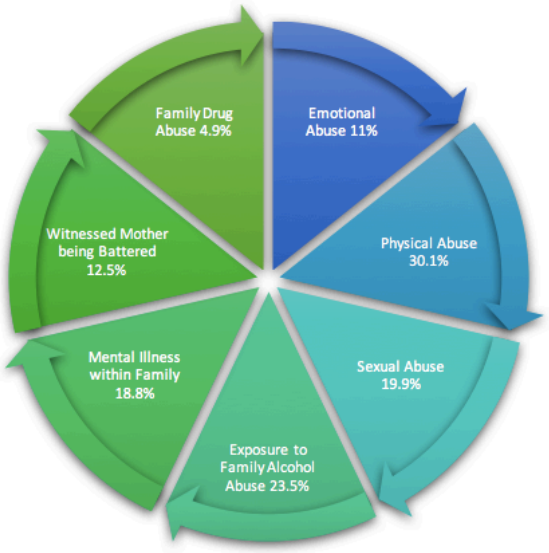

Figure 1. Reported proportions of adverse childh*ood experiences (van der Kolk, 2003)*

The study found a strong parallel between childhood abuse and the following in later life: depression, suicide attempts, drug and alcohol abuse, sexual promiscuity, sexually transmitted diseases, domestic violence, smoking, obesity and physical inactivity (van der Kolk, 2003). This study showed that childhood trauma has severe and long lasting impacts on the child. There is also a significant impact on the economy, as adults of childhood trauma often require medical care. This is a result of the increased likelihood that individuals will develop medical conditions such as; cancer, heart disease, stroke, diabetes, skeletal fractures and liver disease as a consequence of adopting unhealthy coping strategies to deal with childhood trauma (van der Kolk, 2003). The direct and indirect cost to the Australian community as a result of childhood relational trauma in 2007 was estimated to be between $10.7 billion and $30.1 billion dollars. Costs include costs of crime, additional staffing resources required in the education system, health care needs, accommodation, foster carer remuneration, law enforcement and more (Taylor et al., 2008).

The Neurobiology of Childhood Trauma

Studies have shown a distinct difference of the impact on an individual between a one-time traumatic event (such as witnessing a robbery or a car accident) compared to chronic reoccurring interpersonal trauma such as abuse or neglect (van der Kolk, 2014). Interpersonal trauma has pervasive effects on the neurobiological development of children. Children exposed to trauma experience interrupted development in most areas including: how they see themselves in the world, emotional intelligence, development of social skills, cognitive development, physical health and the capacity to have safe and trusting relationships with self and others (Eth & Pynoos, 1985; Perry, Pollard, Blakely, Baker, & Vigilante, 1995; Perry & Szalavitz, 2006; van der Kolk, 2014). The impacts of such

disruptions effect children in aspects of their body, memory, relationships, emotions, learning, behaviour and brain development.

Otnitz (1996) proposed that there are four critical periods where the developing brain undergoes significant structural change. These periods are: 15months – 4 years (early childhood), 6 years -10 years (late childhood), puberty, and mid-adolescence (as cited in van der Kolk, 2003). Chronic stress in childhood can cause significant changes to the way the brain functions as a result of the stress occurring during a period of time that is especially sensitive to brain growth and development (Teicher, Andersen, Polcari, Andersen & Navalta, 2002). The earlier the trauma occurs the more detrimental the impact it has on the child (Perry & Szalavitz, 2006). Children exposed to childhood trauma have a decreased corpus callosum volume, smaller brain size, smaller prefrontal cortex and cerebral volumes, larger ventricles and frontal lobe cerebrospinal fluid volumes (De Bellis et al., 2002). As a result, children are prone to misinterpret sensory input and are primed to experience danger and threat, even in the absence of objective triggers for such responses (van der Kolk, 2003).

Trauma breaks the bonds of attachment and security, which is understood to be the foundation of a stable and coherent sense of self (Perry et al., 1995). van der Kolk et al. (1966) reported that children who have experienced trauma often experience problems "with self-regulation, aggression against self and others, problems with attention and dissociation, physical problems and difficulties in self-concept and capacity to negotiate satisfactory interpersonal relationships" (as cited in van der Kolk, 2003, p. 293-294). Impacts of these difficulties can include isolation, unhealthy coping choices, rejection from family members, peers and from teachers. van der Kolk (2003) argues that you cannot discuss trauma in children without giving appropriate attention to the parent-child attachment. Children's responses to challenging and traumatic experiences largely mimic those of their caregivers. The more a parent/caregiver is able to remain a calm, safe and predictable source of comfort

the more a child can begin to regulate and feel safe. The more chaotic and dysregulated a parent is, the more disorganised the child will be (Perry, 1995).

When relational trauma occurs it affects the one mitigating factor (secure attachment) by destroying a child's experience of being kept safe and protected by those around them. Relational trauma interferes with the child's capacity to integrate information that is made up of emotional, cognitive and sensory cues into a cohesive whole. This is the result of trauma overwhelming a child's capacity to cope (Perry & Szalavitz, 2006). Fragmentation and splitting can occur as a response to trauma. Fragmentation refers to the event or series of events overwhelming the entire organism, and as a result the child is not able to integrate and make sense of the experience. Splitting is a mechanism for coping that results in failure to view experiences in a flexible way and instead the child views experiences in extremes or "black and white thinking" (Taylor, 2014).

Attachment Theory

Attachment Theory was jointly founded by John Bowlby and Mary Ainsworth. Attachment is an intrinsic need in infants that motivates them to seek closeness with their primary caregiver (Cassidy & Shaver, 2016). The repeated interaction between infant and caregiver becomes encoded in the implicit memory of the infant. The significance is such that it creates a foundation of attachment patterns for future relationships. It has been suggested that these initial attachment states remain relatively stable across one's life without intervention (Karen, 1994). There are four categories of attachment theory: secure, preoccupied (anxious), dismissing (avoidant) and disorganised attachment. Bowlby (1979) believed that the responses an infant receives for their requests for care and safety, particularly when the infant is in distress becomes a symbolic working model; the child's

world view (how they believe others will be able to meet their needs) and whether they see themselves as worthy or unworthy of love (Karen, 1994).

Secure Attachment

Secure attachment is when the caregiver is attuned to the child and regulates the child's positive states and states of distress (Schore, 2001). This lays the foundation for a growth promoting environment to be constructed which enables the child to build their own capacity for emotional regulation and to learn to flexibly respond to their environment (Schore, 2001). Infants with secure attachment show distress when their carer leaves them and display happiness upon their carer's return. Typically, the infant will seek the need for closeness and when satisfied will return to their exploratory play. Characteristics of securely attached individuals include high self-esteem, emotional intelligence and an interest in social relationships and getting support from others (Bowlby, 1979). Children who experience secure attachments have caregivers who are emotionally available to them and respond appropriately and timely both when the child is experiencing positive emotions or when they are in a state of distress (Karen, 1994). The caregiver allows for high levels of shared play states that are based on positive affect and low levels of distressing interactions or ruptures (Schore, 2001).

Preoccupied (Anxious) Attachment

Individuals with anxious attachments have a preoccupied caregiver which results in the child experiencing inconsistent responses from them (Bowlby, 1979). As a way of coping with the inconsistency and attempting to get their needs met, the child learns to concentrate on their caregiver instead of focusing on play or exploring. This is because the child does not know when they will get the response they are needing and so they become hyper-vigilant, focusing on their caregiver, attempting to maximise any opportunity for attuned responses

(Cassidy & Shaver, 2016). The child may also cling or express anger toward their parent (Karen, 1994).

Dismissing (Avoidant) Attachment

Children with avoidant attachments believe that seeking closeness in relationships does not result in positive outcomes and as a result they try to distance themselves from intimate relationships (Cassidy & Shaver, 2008). Being vulnerable terrifies them which stems from their early infant experiences when they were not provided safety and warmth when they experienced distress (Karen, 1994). When a child attempts to gain closeness with their caregiver and experiences rejection much of the time, they are primed to develop an avoidant attachment style. To cope with the pain of rejection the child finds means such as focusing their attention on other things or by denying to themselves that they want to experience closeness with their caregiver (Cassidy & Shaver, 2008).

Disorganised Attachment

Disorganised patterns are developed when a caregiver is threatening, dangerous or extremely inconsistent with their responses. This is attachment style is found predominantly in children who have been abused or neglected (Schore, 2001). The child may develop behaviours that lack organisation, such as self-harming, dissociating or behaving in unpredictable ways (Cassidy and Shaver, 2008). For children who experience relational trauma from their primary carer, the caregiver demonstrates diminished play with the child. The caregiver is also the source of stress and can induce traumatic states within their child (Schore, 2001).

Parenting Style Dimensions

Schaefer (1959) first introduced a model that described an overall pattern of parenting behaviour. This model consisted of three different constructs: acceptance versus rejection,

psychological autonomy versus psychological control, and firm behavioural control versus lax behavioural control. Baumrind (1966, 1968) expanded on this model and determined three different parenting styles; authoritative, authoritarian and permissive. This research has been extended to include a continuum of responsiveness and demandingness. A fourth parenting style, 'uninvolved', has also been introduced (Maccoby & Martin, 1983). Uninvolved parenting is also referred to as disengaged parenting (Teyber, 2006). Only authoritative, authoritarian and permissive parenting styles will be expanded on here due to existing research largely excluding discussion of the disengaged parenting style.

As shown in Figure 2 demandingness can be thought of as parenting behaviour that intends to provide structure, rules and clear expectations for the child. Responsiveness can be thought of as parenting behaviours that intend to foster a child's individuality, the ability for self-regulation and agency that occurs through the experience of attunement (Teyber, 2006). Demandingness and responsiveness and warmth and control can be best understood as existing within a quadripolar framework as shown below.

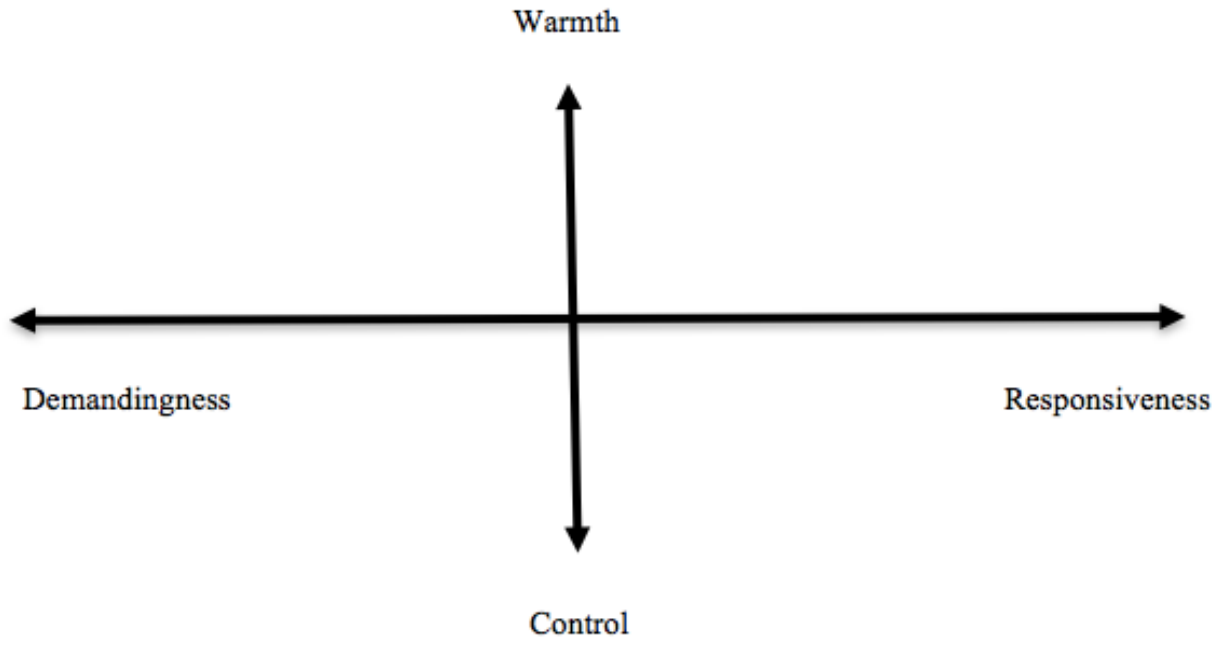

Figure 2. A quadripolar representation of parental demandingness and responsiveness and warmth and control.

Authoritarian Parenting Dimension

Authoritarian parenting styles are categorised as a power oriented style whereby the parent attempts to shape and control the attitudes and behaviours of the child by asserting power over the child (Baumrind, 1968). The authoritarian parenting style is high on demandingness and low on warmth/ responsiveness. The parent has a strong expectation for their child to rigidly comply with the rules (Teyber, 2006). Characteristics that make up authoritarian parenting are; demandingness, directedness, intrusive, non-responsive and an expectation of obedience from their child without explanation (Baumrind, 1966). Children with authoritarian parents go without the emotional warmth and affection that contributes to the development of a strong sense of belonging and security. An impact from this style of parenting is that children learn to hide their distress and vulnerability from their parent and eventually from themselves (Baumrind, 1966). These children are often successful in school and later in their chosen careers as adults. However, they tend to keep people at a distance and convey an unspoken message "I don't need you or anyone else". They also tend to keep their emotions under tight control. Children with authoritarian parents may tend to develop an avoidant attachment style (Teyber, 2006).

Authoritative Parenting Dimension

The authoritative parent is categorised by flexible control and high warmth. They are considered to be high on demandingness and high on responsiveness (Teyber, 2006). The parent sets clear expectations for their child and monitors them; however, they are able to do this in a way that is not restrictive or intrusive. These parents are good at setting firm boundaries with their child, whilst maintaining openness to their child's thoughts and needs (Baumrind, 1966). The parent encourages their child to be involved in decision making where appropriate. Parents act in a supportive manor rather than in punitive ways toward their child. Children of authoritative parents tend to be the most well-adjusted of all the

parenting styles. They grow up knowing they can expect good things from relationships such as warmth and affection whilst also learning to be responsible and to respect authority figures (Teyber, 2006).

Permissive Parenting Dimension

The permissive parent tends to be lenient with their child and does not have high expectations for their child's behaviour. The parent is low on demandingness and high on responsiveness (Baumrind, 1966). When there are problems that need to be addressed, the parent often avoids confrontation with their child out of apprehension of how their child will feel toward them (Baumrind, 1968). The parent is generally accepting of their child's impulses, desires and actions without implementing appropriate boundaries. The permissive parent does not use power oriented parenting strategies such as the authoritarian parent, however they tend to utilise reason or manipulation to get their child to comply (Teyber, 2006). Children with permissive parents tend to struggle with achieving independence and knowing how to succeed on their own. This is because they often lacked discipline, clear expectations and learning how to be responsible. Children with permissive parents often develop anxiety, depression or externalising behaviour problems (Teyber, 2006). They do not feel safe because they do not experience that their parent can protect them because there are few or no boundaries (Baumrind, 1966).

Common treatment approaches: Strengths and limitations

The Australian Psychological Society (2010) conducted a literature review on evidence-based interventions for working with children. The findings suggested that for disorders such as depression, generalised anxiety, obsessive compulsive disorder, sleep disorders, chronic fatigue, attention deficit hyperactivity disorder (ADHD), conduct and

oppositional defiant disorder (ODD), cognitive behaviour therapy is the therapy of choice for children and adolescents.

For disorders such as posttraumatic stress disorder, somatisation and dissociative disorders, no recent studies were found to indicate superior effectiveness of any single treatment approach. This is noteworthy, as children who have experienced trauma are most commonly diagnosed with separation anxiety disorder, oppositional defiant disorder, phobic disorders, PTSD and ADHD (Gabowitz, Zucker & Cook, 2008; van der Kolk, 2014). Thus, to date, there is an absence of evidence-based interventions for many presentations precipitated by childhood trauma. Despite this, cognitive behavior therapy remains a common method of intervening with such disorders. What is not as clear is the degree to which cognitive-behavioural therapists, or those from alternative theoretical perspectives, integrate parents within the therapeutic context or utilise play to facilitate treatment gains.

A national survey was conducted with 1,166 play therapists in the United States. Seventy-eight percent of respondents believed that the level of involvement in the therapeutic process for parents and caregivers contributed to treatment success (Phillips & Landreth, 1998). This is a valuable finding, suggesting that parents who do not understand or feel included in their child's therapy are more likely to terminate their child's counselling prematurely (Cates, Paone, Packman, & Margolis, 2006; Van Fleet, 2000). "Parent's thoughts about play and its value for children may have a direct impact on what they think about the therapeutic use of play" (Brumfield & Christensen, 2011, p. 209).

There is limited literature on parental involvement in their child's therapy involving play, however there is a growing body of research emphasising the importance of parental involvement in therapy sessions and outside of the therapy sessions with their child (Yap et al., 2016). Children who had a highly involved parent participate in their CBT sessions demonstrated significantly greater improvements in anxiety symptoms than those who did

not. Parents were also found to be an important factor in applying skills and strategies outside of the therapy sessions to further alleviate anxiety symptoms (Pereira et al., 2015). In a study by Falk, Norris and Quinn (2014) investigating factors that predicted stress, anxiety and depression in parents of children with autism it was found that it was important when offering support to parents that the focus must not only be on their child. This finding is useful to apply in the context of using play to work with children who have experienced trauma, as it is likely that the parent will need support that not only emphasises the value of play for children but that also supports parents to understand their own history and how that may play a role in their current attitudes and beliefs with regards to their child's therapy.

Though cognitive behaviour therapy (CBT) is a favoured approach for many of the disorders listed above, there may be limitations applying this approach when working with children. Because CBT emphasises understanding how thoughts relate to behaviour it can mean relying on talking with children about complex issues. Abstract thought can be beyond a child's capabilities at the best of times and further inhibited for children who have experienced trauma. Neurobiology research informs us that children who have experienced complex trauma often cannot function at the higher level of their brain, the prefrontal cortex (Perry et al., 1995; van der Kolk, 2003).

The ability to think through life events, form a narrative and process these experiences requires the work of the frontal lobes in the brain (Homeyer & Morrison, 2008). This part of the brain is underdeveloped in children and adolescents and therefore therapies that concentrate on verbalisation and cognitive reflection, e.g. CBT, may not be as viable options for children. van der Kolk (2014) conducted a study that looked at people's brains while they were having a flashback related to trauma. One of the findings from this study was that a region in the brain called Broca's area stopped working when a patient from the study experienced a flashback. Broca's area is known to be one of the speech centre's in the brain,

this finding was significant in that it demonstrated that when people are triggered and reliving their trauma they are not able to put into words how they feel and what they think (van der Kolk, 2014). van der Kolk (2014) describes that the disorganised sensation that forms the core imprint of trauma in the brain cannot be integrated through words, therefore treatment needs to incorporate the actions and sensations that have become stuck because a child is not able to articulate their experience of trauma. This is where play can contribute a meaningful role in therapy and processing trauma.

Taylor (2014) reports that individuals with complex trauma are thought to be less responsive to traditional therapies due to needing to build a strong therapeutic relationship with their therapist in which they feel safe, which can take an extended period of time considering the trauma they have experienced. CBT is effective with some child and adult trauma clients, however it emphasises observable outcomes, symptom alleviation, as well as being goal-oriented and time-limited. A limitation to this approach is that clinicians may fail to meet the complexity of the child's individual needs based on implementing manualised treatment plans (Taylor, 2014), or feeling bound to shorter time-frames to effect change.

The use of play in therapy for traumatised children

Children play when they feel safe. Feeling safe comes from experiencing a calm and predictable world where children know what to expect from the adults around them (Perry, Hogan & Marlin, 2000). The Office of United Nations High Commissioner for Human Rights acknowledged that play is a right for all children and it is essential in order for children to achieve healthy develop (Homeyer & Morrison, 2008). Play holds a critical role in all areas of development for children including; cognitive, language, social-emotional and psychological (Johnston et al., 2005; Parmar, Harkness, & Super, 2004). Children develop their understanding of how the world works through the process of play and combining a

pretend narrative with one's reality. (Brown, 2010). Johnson and Chang (2007) also reported that playing well and developing well are a parallel process.

The absence of play in childhood can profoundly and negatively impact an individual and result in extremely maladaptive behaviours (Brown, 2010). Erikson (1964) believed that play had an essential role in children developing their personality. Piaget (1962) advocated that children and adults are different in how they understand, process and communicate information and therefore play is a vital part of development for children. Because children's brains are still developing they have a reduced capacity to articulate their experience with words. Play is a more developmentally appropriate way for children to communicate. Children use toys as their words and play as their language (Landreth, 2012).

The presence of a caregiver who can support the child to modify their level of physiological arousal is what is required for the development of normal play and exploratory activity (Perry, 2001). Play holds great importance for children to express their feelings and gain mastery over fears (Levine & Kline, 2006). Through play children can act out and project onto toys and objects their inner world and experiences (Landreth, 2012). Play involves physical activity and an opportunity to play out the event which assists the brain in moving the memory from the nonverbal parts of the brain to the frontal lobes. Play allows for the opportunity for children to make the unmanageable, manageable (Landreth, 2012). When a child comes to therapy related to trauma, play can be a vehicle for healing and repairing the relationship between the child and caregiver when it is appropriate and safe to involve the caregiver (Hill, 2009).

Play in Therapy vs. Play Therapy

The use of play in therapy allows children to work through challenging or overwhelming experiences in a way that feels safer. Through play children can work towards integrating their experiences and developing an internal resolution for certain difficulties

through the use of metaphors and symbolism (Landreth, 2012). When children play social, emotional and neurological development takes place, while they process complex and confusing experiences (Landreth, 2012).

All child therapists, regardless of their theoretical orientation, can find ways to include play in therapy sessions although they may not implement play therapy orientations. Examples of integrating play into therapy could be the use of music, rhythmic movements, toys, games, imaginative play, or role-play to facilitate child progress. In contrast, play therapy is a specific modality that requires specialised training for working with children. There are several different theoretical approaches to play therapy including: gestalt play therapy, child centered play therapy, Adlerian play therapy and prescriptive play therapy (Bratton, Ray, Rhine, and Jones, 2005). These approaches take different stances on how much the therapist directs play with the child in the session.

Parental Perceptions Towards the use of Play in Therapy

There is minimal literature on parental perceptions of their child's therapy in general, and even less so relating to the use of play in therapy. However, working with parents increases the likelihood of therapeutic success for children (Cates et al., 2006) and as such needs to be a priority when undertaking both research and interventions with child populations. The lack of literature in this area is a crucial oversight as researchers have demonstrated the importance of parental involvement in their child's therapy (Kraft & Landreth, 1998). Parental involvement can support progress within sessions as well as facilitating out of session gains and progress for the child.

The largest meta-analysis to date on the use of play in therapy (which includes but is not limited to play therapy) compiled 93 research studies from the period of 1953- 2000 and revealed an effect size of .80. This effect size was the outcome for each individual study and a high effect size indicated play therapy was an effective intervention across a wide range of

issues (Bratten et al., 2005). An even larger effect size of .92 was found for the studies that involved professionals working from a child-centered play therapy, otherwise known as non-directive therapy. Even more effective were approaches that included parents and other significant adults in the child's life (Cohen's *d*=1.05; Bratton et al., 2005). Despite these findings, capturing the voices of parents and caregivers has been limited and parent's views of the effectiveness of various treatment models remains overlooked (Boswell, 2014).

According to Wehrman and Field (2013) parent resistance to play in therapy is a common challenge. Some possible reasons that parents may resist the use of play in therapy include uncertainty about the value of counselling and discomfort about play being part of the process. Parents may view talking about the problem as the only way to create change, and may see play-based activities as detracting from the "real work". Some parents may feel uncomfortable participating in play with their child due to the parent lacking confidence, self-efficacy or the ability to engage spontaneously and creatively with their child in play. This is possibly connected the parent's own parenting style and the style of parenting they received as a child. A child is more at risk of experiencing relational trauma if their parents have experienced abuse (Thornberry & Henry, 2012).

Parents can feel overwhelmed with the expectation to go 'off script' and interact with their child in different ways and may ask questions such as "how can just playing help my child"? (Vanfleet, 2000). Some researchers have suggested that ongoing parental involvement in the use of play within the therapy process leads to greater parental satisfaction and a decrease in the problem behaviours identified in the child (Kottman, 2001) due to greater parent-child attunement and a higher number of positive interactions.

Parent Willingness to Seek Psychological Help

It is thought between 17- 20% of children have a diagnosable disorder with externalising problems being the most common; however, fewer than 5% of children receive

mental health treatment. The most significant factor to whether a child receives treatment is whether the parent decides to seek help (Dempster, Wildman, & Keating, 2013). Stigma is one of the most influential factors determining whether an adult seeks help (Corrigan, 2004). If a parent believes they will be blamed or judged as being a "bad parent" this may further prevent their willingness to access appropriate mental health services (Dempster, Wildman, & Keating, 2013). Children are dependent on their parents regarding whether they access mental health treatments and therefore understanding parental behaviour and willingness to seek help for their children is important to consider (Raviv, Sharvit, Raviv, & Rosenblat-Stein, 2009).

The Present Study

Rationale

Childhood trauma is a pervasive problem in Australia and worldwide. Adverse childhood experiences have a severe and devastating impact on children as well as in the community and on the economy. When trauma occurs within a relationship, healing can only occur through relationships. There is limited literature on parental and caregiver's experiences of their child's counselling in general, and particularly regarding attitudes towards the use of specific therapeutic techniques such as play. Of all the life experiences, the early experiences of childhood have the most important and lasting effects on how the brain organises information and functions. Play is an inexpensive and efficient way to help children develop. Teaching parents who do not understand the value of playing with their child simple techniques such as music and rhythmic activities seems to have powerful and positive impacts on children (Perry, Hogan & Marlin, 2000). The best toy for a child is a parent who takes an active interest and willingly interacts with their child in play.

It has been argued that the use of play within therapy to support children who have

experienced trauma can enhance treatment outcomes by facilitating ways that feel manageable for children to process their traumatic experiences. Given the need to include and understand parents and caregiver's attitudes and experiences the current research project aimed to explore the attitudes and beliefs toward play whilst taking into account parenting style, attachment and willingness to seek psychological help.

Aim

The aim of the present study was to contribute research to the area of parental attitudes and perceptions with regards to the use of play in therapy. Parental attitudes towards their child's therapy is an overwhelmingly under-researched area, yet studies show that parental involvement in their child's therapy has a large influence on child outcomes (Cates, Paone, Packman, & Margolis, 2006; Kraft & Landreth, 1998; Bratton et al, 2005).

Hypotheses

It was hypothesised that parental attitudes towards the use of play in therapy would be positively predicted by parent-child attachment, authoritative parenting style and willingness to seek professional psychological help.

Method

Design

The research was a cross-sectional correlation design. A series of backward stepwise regression analyses were performed to assess the predictive capacity of parent-child attachment and three different parenting styles (authoritative, authoritarian and permissive) on two dependent variables; the first being the significance of play and the second dependent variable the value of play in the parent-child interaction within a therapeutic context.

Participants

The sample consisted of parents and caregivers residing throughout Australia with a child between the ages of 0-18 years who had been impacted by trauma. Participants were recruited through the Australian Childhood Foundation employees informing parents/caregivers about the study and by placing flyers up in the waiting room. Other organisations were also contacted and asked to place fliers up in their waiting areas including; Child and Adolescent Mental Health Services, Sexual Assault Support Service, Catholic Care and Children and Young Persons Program, the Chief Investigators professional twitter account as well as private counselling and psychology practices. Pro-ration was used for missing values, allowing all 73 respondents to be included in the final participant sample. The mean age of participants was 27.68 years, and the SD was 7.87.

Materials

Cronbach's alphas obtained for each measure used in the current study are contained in Table 1.

Parental Play Beliefs Scale. The Parental Play Beliefs Scale (PPBS; Jiang and Han 2016) is a 26-item self-report questionnaire that measures parental beliefs about play. The items assess parental beliefs about play on a five-point Likert scale ranging from (1) Strongly

Disagree to (5) Strongly Agree. The PPBS produces a separate score for each category, with higher numbers indicating greater reported value of play. The research used the modified scale by Jiang and Han (2016) which measured three subscales; parental attitudes towards the developmental significance of play, parent-child interaction and the value of play and the value of play compared to academic activities.

The developmental significance of play subscale included consisted of 6 items with examples such as "play helps my child to express his or her feelings" and "play can help my child develop better thinking abilities" (Fogle & Mendez, 2006). Parents and carers who scored high on this category endorsed positive beliefs about the value of play and the significance it has for the development of children (Howrath-Oliver, 2015). The second subscale, parent-child interaction, consisted of 12 items with examples such as "my child has a lot of fun when we play together" and "it is important for me to participate in my play with my child" (Fogle & Mendez, 2006). High scores on this category indicate the positive beliefs parents and carers hold about the value of playing with their child and participating together in play.

The value of play compared to academic activities category consisted of 8 items with examples such as "I do not think my child learns important skills by playing" and "I would rather read to my child than play together" (Fogle & Mendez, 2006). This category represents negative beliefs about the value of play. Parents and carers who scored high in this category are likely to perceive play as irrelevant or not as important to their child's social and emotional development (Howrath-Oliver, 2015). This category was not included in the data analysis due to low reliability (refer to Table 1).

*Parent/child attachment scale***.** (PCAS; Thornberry, Lizotte, Krohn, Farnworth & Jang, 1991) is a 11 question scale that measures the degree of warmth and lack of hostility between parent and child. The items assess parent-child attachment on a four-point Likert

scale ranging from (1) Never to (4) Often. The PCAS produces one score with high numbers indicating greater parent-child attachment. Internal reliability and consistency is reported by the authors as α =.81 (Thornberry et al., 1991). There is a parent version of the scale and a child version, for the purpose of this research only the parent-child attachment scale was used.

*Parenting styles and dimension questionnaire***.** The Parenting Styles and Dimensions Questionnaire (PSDQ; Robinson, Mandleco, Frost, Olsen & Hart, 2001) is a 62-item self-report questionnaire that measures Baumrind's (1971) three parenting styles; authoritative, authoritarian and permissive. The items assess parenting practices on a five-point Likert scale ranging from (1) Never to (5) Always. The scale has both a self-report and spousal report option, only the self-report feature was used for this study. The PSDQ produces a separate score for each identified parenting style, with high numbers indicating greater reported use of a particular parenting style.

The Authoritative scale comprises 27 items and includes items such as "has warm and intimate times together with child" and "expresses affection by hugging, kissing and holding the child" (Robinson et al., 2001). The Authoritative scale is made up of the following subscales; warmth and involvement (11 items), reasoning/induction (7 items), democratic participation (5 items) and good natured/easy going (4 items). The Authoritarian scale comprises 20 items and includes statements such as "explodes in anger towards child" and "punishes by putting child off somewhere alone with little if any explanations" (Robinson et al., 2001). The Authoritarian scale measures subscales for the following; verbal hostility (4 items), corporal punishment (6 items), non-reasoning/punitive strategies (6 items) and directedness (4 items). The Permissive scale is made up of 15 items and includes statements such as "Ignores child's misbehaviour" and "gives into child when he/she causes a commotion about something" (Robinson et al., 2001). The Permissive scale measures

subscales for the following; lack of follow through (6 items), ignoring misbehavior (4 items) and self-confidence (5 items). Internal consistency reliabilities were averaged for mothers' and fathers' reports and found to be α = .87, α = .91 and α = .88 for the Authoritative, Authoritarian and Permissive scales (Robinson et al., 1995).

Attitudes Towards Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF; Elhai, Schweinle & Anderson, 2008). The ATSPPH-SF is a 10 question scale that measures three components; (1) openness to seeking professional help for emotional problems, (2) the value in seeking professional help and (3) coping on one's own and choosing not seek psychological help. The items assess the three categories on a four-point Likert scale ranging from (3) Agree to (0) Disagree. Higher scores indicate more positive attitudes toward seeking professional help (Picco et al., 2016).

Table 1.

Internal Reliability of Scales

Scale	α
PPBS	
Significance of play	.93
Interaction and play	.78
Play compared to academic activities	.03
PSDQ	.72
PCA	.93
ATSPPH-SC	.84

PPBS (Parental Play Beliefs Scale)
PSDQ (Parenting Styles Dimension Questionnaire)
PCA (Parent Child Attachment)
ATSPPH-SC (Attitudes Toward Seeking Professional Psychological Help- Short Form)

Sociodemographic information was also recorded, including gender, age, occupation, ethnicity, relationship status, income, cost for service, number of children, ages of children, type of trauma their child experienced, and perceptions and experiences relating to their child's counselling.

Procedure

Prior to conducting the research, ethics approval was obtained by the Tasmanian Social Sciences Human Research Ethics Committee (Appendix A2). To access the online survey, participants went to the specified web link that was included on the participant information sheet. Consent to participate in the study was implied through the submission of the survey. This was outlined in the participant information sheet that appeared on the first page when participants opened the link to the online survey. Participants were asked a series of demographic questions and a series of questions about their experience of taking their child to counselling prior to responding to the four standardised questionnaires.

Results

Prior to conducting analyses, all variables were assessed with tests of normality. Assumptions of linearity, independence, collinearity, homoscedasticity, and normal distribution were met. All correlations between variables were below .71. Table 1 documents the means (M) and standard deviations (SD) of the predictor and outcome variables. To further ensure multicollinearity was not an issue Tolerance and Variance Inflation Factor (VIF) were examined. Following the recommendations of Field (2013), Tolerance levels below 0.1 and VIF levels above 10 are cause for concern. Within the current study, no levels of Tolerance were found to be below 1 and no VIF levels were found above 10.

Multiple regression analyses

Despite the identified limitations of backward stepwise regression, to use an alternative method of regression analysis would be inappropriate considering the exploratory nature of the research, and would likely produce unreliable results (Goodenough, Hart & Stafford, 2012). Due to limitations imposed by sample size, a series of three separate stepwise regressions were conducted to determine the predictive utility of parent-child attachment and parenting style on beliefs about play in therapy. Further, due to low internal reliability estimates, BAP academic focus was not included as an outcome variable for any of the analyses. Only malleable factors were included in the analysis, as these can be targeted for intervention. Demographic factors were excluded based on the decision that although they may provide interesting correlations, they are factors that cannot be changed and therefore would have limited benefit for clinical implications.

Table 2.

Predictor Variables Means and Standard Deviations

Scale/Subscale	Mean	SD
PCA	32.70	6.00
Warmth	41.59	6.40
Reasoning	25.03	3.76
Democracy	15.86	3.16
Easy Going	12.71	1.79
Hostility	6.99	2.71
Punishment	8.40	4.49
Non-reasoning	10.86	4.45
Directiveness	10.10	3.63
No Follow Through	14.33	3.30
Ignoring	8.63	1.41
Self Confidence	13.51	1.73
ATSPPH-SF	24.71	4.37

PCA: Parent-child Attachment
ATSPPH-SF: Attitudes Toward Seeking Professional Psychological Help Scale- Short Form

The model examining the influence of parent-child attachment along with authoritative parenting practices as shown in Table 3 was able to account for 51.7% (Adj. R^2) of the variance in beliefs about the significance of play in therapy, $F(5, 67)=16.44$, $p<.001$. High levels of warmth and reasoning positively predicted the value of play in therapy, whereas lower levels of democracy, parent-child attachment, and easygoing nature all negatively correlated with beliefs regarding the significance of play in therapy (Table 3). Authoritative warmth was the most influential predictor.

Table 3.

Regression Between Subscales of Authoritative Parenting Style Dimension and PCA

Variable	Std. Beta	*t*	*p*	95%CI
Parent Child Attachment	-.104	-.906	.368	-.265-.100
Authoritative Parenting Style Dimension				
Warmth	.862	5.381	<.001	.405-.882
Reasoning	.204	1.875	.065	-.017-.533
Democracy	-.254	-2.125	.037	-.746--.023
Easy Going	-.026	-.026	.829	-.712-.573

PCA: Parent Child Attachment

The model examining the influence of parent-child attachment along with authoritarian parenting practices as shown in Table 4 was able to account for 36.8% (Adj. R^2) of the variance in beliefs about the significance of play in therapy, $F(5, 67)=9.38$, $p<.001$. Punishment positively predicted the significance of play in therapy, whereas lower levels of non-reasoning, hostility, directiveness and parent-child attachment all negatively correlated with beliefs regarding the significance of play in therapy (Table 4). Non-reasoning was the only significant predictor.

Table 4.

Regression Between Subscales of Authoritarian Parenting Style Dimension and PCA

Variable	Std. Beta	*t*	*p*	95%CI
Parent Child Attachment	-.092	-.622	.536	-.308-.162
Authoritarian Parenting Style Dimension				
Hostility	-.350	-1.363	1.78	-1.520-.287
Punishment	.462	1.780	.080	-.060-1.042
Non-Reasoning	-.663	-2.058	.043	-1.401--.021
Directiveness	-.137	-.550	.584	-.831-.472

PCA: Parent-child Attachment

The model examining the influence of parent-child attachment along with permissive parenting practices as shown in Table 5 was able to account for 46.6% (Adj. R^2) of the

variance in beliefs about the significance of play in therapy, $F(4, 68)=16.68$, $p<.001$. Parent-child attachment and self-confidence positively predicted the significance of play in therapy, whereas no follow through negatively correlated with beliefs regarding the significance of play in therapy. Parent-child attachment, self-confidence and no follow through were all significant predictors (Table 5).

Table 5.

Regression Between Subscales of Permissive Parenting Style Dimension and PCA

Variable	Std. Beta	*t*	*p*	95%CI
Parent Child Attachment	.463	4.180	<.001	.192-.543
Permissive Parenting Style Dimension				
No Follow Through	-.476	-4.520	<.001	-.992- -.384
Ignoring	.133	1.426	.158	-.180-1.081
Self Confidence	.579	5.312	<.001	.995-2.193

PCA: Parent Child Attachment

The Value of Play in Parent-Child Interactions

The model examining the influence of parent-child attachment along with authoritative parenting practices as shown in Table 6 was able to account for 48.6% (Adj. R^2) of the variance in beliefs about the value of play within the parent-child interaction, $F(5, 67)=14.59$, $p<.001$. Parent-child attachment positively predicted the value of play within the parent-child interaction (Table 6). Parent-child attachment was the only significant predictor in this model.

Table 6.

Regression Between Subscales of Authoritative Parenting Style Dimension and PCA

Variable	Std. Beta	*t*	*p*	95%CI
Parent Child Attachment	.419	3.525	.001	-2.257-18.4
Authoritative Parenting Style Dimension				
Warmth	.316	1.912	.060	-.015-.680
Reasoning	.052	.468	.641	-.307-.494
Democracy	-.101	-.818	.416	-.742-.310
Easy Going	.114	.911	.366	-.509-1.363

PCA: Parent Child Attachment

The model examining the influence of parent-child attachment along with authoritarian parenting practices as shown in Table 7 was able to account for 58.4% (Adj. R^2) of the variance in beliefs about the value of play within the parent-child interaction, $F(5, 67)=21.19$, $p<.001$. Parent-child attachment and punishment positively predicted the value of play within the parent-child interaction, whereas hostility and non-reasoning negatively correlated with beliefs regarding the value of play within the parent-child interaction (Table 7).

Table 7.

Regression Between Subscales of Authoritarian Parenting Style Dimension and PCA

Variable	Std. Beta	*t*	*p*	95%CI
Parent Child Attachment	.255	2.117	.038	.016-.554
Authoritarian Parenting Style Dimension				
Hostility	-.466	-2.235	.029	-2.193--.124
Punishment	.799	3.792	<.001	.567-1.828
Non Reasoning	-.798	-3.053	.003	-1.998--.418
Directiveness	-.007	-..036	.972	-.759-.733

PCA: Parent-child Attachment

The model examining the influence of parent-child attachment along with permissive parenting practices as shown in Table 8 was able to account for 52.4% (Adj. R^2) of the

variance in beliefs about the value of play within the parent-child interaction, $F(4, 68)=20.78$, $p<.001$. Parent-child attachment and self-confidence positively predicted the value of play within the parent-child interaction, whereas no follow through negatively correlated with beliefs regarding the value of play within the parent-child interaction. Parent-child attachment, self-confidence and no follow through were all significant predictors (Table 8).

Table 8.

Regression Between Subscales of Permissive Parenting Style Dimension and PCA

Variable	Std. Beta	*t*	*p*	95%CI
Parent Child Attachment	.609	5.825	<.001	.448-.916
Permissive Parenting Style Dimension				
No Follow Through	-.333	-3.353	.001	-1.085--.275
Ignoring	.165	1.867	.066	-.054-1.626
Self Confidence	.251	2.441	.017	.178-1.773

PCA: Parent Child Attachment

Discussion

The purpose of this study was to contribute to the limited research that exists on parental attitudes toward the use of play in therapy for children impacted by trauma by examining parent-child attachment, parenting style dimensions and attitudes toward seeking psychological help. The results of this study provide partial support for the hypothesis that parental attitudes towards the use of play in therapy would be positively predicted by parent-child attachment, authoritative parenting style and willingness to seek psychological help**.** Parent-child attachment was only a factor when examining the permissive parenting style with regards the significance of play, however parent-child attachment was a significant factor for all parenting styles with regards to interaction in play with parent and child. Additionally, there were sub categories in all parenting styles that predicted whether parents valued or did not value the use of play in therapy.

The Significance of Play in Authoritarian Parenting

Warmth, Democracy and Play

For children to feel safe and interested in playing, they require the presence of a caregiver who is able to provide attuned and soothing responses (van der Kolk, 2003). This can be characterised by the qualities that authoritative parenting styles provide for example warmth, which provides soothing experiences and stimulation which comes from flexible control, containment and boundaries within the environment.

The more democratic a parent is the less they were found to value play in therapy for their child. This can be understood in distinguishing the underpinning principles of democracy and play. Democracy is grounded on equality and fairness (Morrissey & Gondoli, 2012). One could postulate that parents who scored high in democracy may be higher in control, though this was not specifically measured in this study. Play is not a democratic process. Play requires the parent to let go, to follow their child's lead and to surrender

expectations of control and fairness. Many children are adept at making up rules, changing the rules to suit their needs in games, and spontaneously introducing variations to the original agreed upon parameters of play. For parents to find play enjoyable the need for democracy interferes with allowing the child to take the lead. It is noteworthy that reasoning was just shy of being a significant factor in the value of play, given that non-reasoning was a significant factor in the authoritarian parenting style this could be a result of low power in the study.

Interaction in Play for Authoritarian Parenting

Parent-child Attachment

The only significant predictor toward parent-child interaction in play on the authoritarian parenting dimension was parent-child attachment. The more securely attached the parent is to their child the more they tend to interact with their child in their child's play. This finding is consistent with attachment theory, the more the caregiver attunes to the child, creates a sense of safety for the child through interacting with the child and being responsive naturally the more involved a parent will be with their child through play. Conversely, if a parent has low attachment with their child this suggests that they are less likely to interact with their child's play. Implications of this finding for clinical practice are that parents with low attachment to their child may be less likely to engage with their child in play, and if this is a mode of intervention being used by the therapist, may undermine therapeutic gains. As such, it may be that parent-child attachment should be screened at the commencement of therapy through the use of a quick and easy tool to administer such as the Parent-Child Attachment Scale to gain insight into whether attachment skills with the parent is required as part of beginning the therapeutic process before seeing the child. Warmth was just shy of being a significant factor, given that it was significant for the significance of play, it is noteworthy and useful to consider the low power of this study which may have effected warmth reaching significance.

The Significance of Play in Authoritative Parenting

Non-reasoning and Play

The more reasoning a parent is the more they were found to value play. This finding contributes to the knowledge that it takes awareness on the parent's part to understand the value of play for children. For parents who scored high in non-reasoning, they hold attitudes and beliefs that can be rigid, inflexible and controlling; making statements such as "because I said so!". These traits may interfere with a parent letting go enough to be able to play freely with their child as it requires relinquishing control and stepping into the shoes of the child. Furthermore, the idea of play within therapy can also prove difficult for such individuals as they are likely to perceive therapy as needing to be structured and dealing with the serious issue of trauma through 'serious' interventions.

Interaction in Play for Authoritative Parenting

Parent-child Attachment, Hostility, Punishment and Non-reasoning

The more securely attached the parent and the more the parent punished their child the more they seemed to value interacting with their child in play. The more hostility a parent demonstrated in their parenting practices toward their child and the more non-reasoning a parent was the less they valued interacting with their child in play. These findings may be understood by the notion that the stronger the parent-child attachment, the more involved the parent tends to be with their child and join in their play. Parent's who punish their child using force may attempt to compensate for their harsh responses to their child's behaviour by being actively involved with their child's play when the parent is in a different frame of mind.

The more hostile and non-reasoning a parent is the more they may adhere to conservative parenting ideologies such as "children should be seen and not heard" and therefore are not inclined to be involved and interactive with their child through developmentally appropriate ways such as through play. Parents who meet these

characteristics may need to be worked with by the child therapist in helping them to understand how the use of play has a neurobiological effect in assisting the child in self-regulation and learning about relationships and what behaviours help or hinder developing positive relationships (Gaskill & Perry, 2014). A patient and supportive parent is essential to supporting children to learn through play (Vygotsky, 1967), this is an important area the therapist would need to work with parents on who score high on hostility and non-reasoning

The Significance of Play in Permissive Parenting

Parent-Child Attachment, Self-confidence, No Follow Through and Play

The less a parent follows through on consequences for their child's misbehaviour the less they reported to value the use of play in therapy. This may indicate that because the permissive environment lacks boundaries, structure and containment the child is often free to do what they want and how they want to most of the time, meaning that there is nothing to distinguish regular time versus play. Parents who scored high in parent-child attachment and self-confidence valued the use of play in therapy. For the permissive parenting style parent child attachment was an important factor in the valuing of play. This may be because the permissive parenting has minimal boundaries, structure and containment. Children are often allowed to behave in ways that may be inappropriate with no consequences. All children require boundaries to feel safe. The strength of the parent-child attachment can be viewed as a mitigating factor that provides more safety within the permissive parenting style than those who do not have a strong parent-child attachment.

Parents who scored high in self-confidence valued the use of play in therapy. This is an important finding for the literature and has potential implications for clinical practice. It takes a degree of self-confidence to be able to engage in play as an adult. Play that is child-led requires a parent to be flexible, spontaneous, creative and to be able to tolerate 'looking silly' or 'un-parent like'. One aspect of parent resistance to the use of play in therapy for

their child is that some parents feel uncomfortable participating in play themselves. This can be due to lacking self-esteem, self-efficacy or a sense of psychological freedom that is necessary to be able to participate spontaneously and creatively in play (Wehrman & Field, 2013). The expectation for the parent to participate with their child's play in therapy may therefore be off-putting and result in slower progress or premature termination of therapy by the parent to the detriment of the child.

The finding from the research that self-confidence positively predicts the value of play in therapy provides important understanding for practitioners to identify that extra time is needed to work with the parent first, to build their self-confidence prior to including the child in therapy and encouraging parental involvement in play. "Play, more than any other activity, fuels healthy development children and the continued healthy development of adults" (Perry, Hogan & Marlin, 2000). Depending on the nature of play, growth and change in all parts of the brain can be facilitated. The need for consistent, reliable and predictable and frequent opportunities for play is crucial for children. This calls for the people who provide the majority of experiences for children such as caregivers, parents and teachers to appreciate the role and value that play has in a child's life (Perry, Hogan & Marlin, 2000).

Interaction in Play for Permissive Parenting

Parent-child Attachment, No Follow Through and Self-confidence

The stronger the parent-child attachment and the more self-confidence the parent reported the more they interacted with their child in play. The less the parent followed through on consequences for child misbehaviour the less they tended to interact with their child in play. These findings are consistent with the findings above in relation to the significance of play. For the permissive parenting style in particular a strong parent-child attachment and high self-confidence in the parent are crucial factors in the parent's ability to join in their child's play. It could be considered that this is a result of the permissive

parenting style being characterised as a lax and responsive style of parenting without providing boundaries or containment.

Similarly, the lack of follow through for their child's misbehaviour could be understood in this context as the parent allowing the child to do what they want without intervening or interacting with their child through play because of the hands off approach to containment. It is noteworthy that ignoring their child's misbehaviour was almost a significant factor. As such, knowledge of permissive parenting practices gives the therapist opportunity to address this parenting style through implementing appropriate boundaries for the child, and thereby enhancing child therapeutic outcomes by creating additional feelings of security outside the therapeutic environment. It is a consideration that ignoring did not reach significance due to the study having low power.

Limitations

One limitation of this study was the sample size. Backward stepwise regression analysis was used, however due to the lower sample size of 73 the researchers were not able to run all the variables at the same time. This particular sample group was difficult to engage and challenging to make participation appealing to them. Additionally, this research might have increased benefit by including a qualitative component as there is likely important information that was not only using online scales and questionnaires. It is likely that by meeting with parents and caregivers and establishing a personal interaction more information will be disclosed. There would also be opportunity for clarification regarding perceptions and attitudes toward the use of play in therapy and within the parent-child interaction.

Implications and Directions for Future Research

The results of this study clearly indicate that parenting style dimensions are an important factor in determining whether parents and caregivers value the use of play in therapy for children who have been impacted by trauma. These findings have important

clinical implications as parents who already value play will require less education regarding the use of play in therapy, whereas parents who do not value play will need considerable time spent with the therapist on education as well as supporting the parent to relearn in an experiential way how to play. There is an important need to expand research that emphasises parent and caregiver experiences, attitudes and involvement in their child's therapy in relation to the use of play. The current research could be expanded on to investigate parents and caregivers own childhood history, the parenting style they experienced as a child and how they experienced the presence or absence of their parents interacting with them through play and to explore if there is a connection with their value of the use play in therapy.

Conclusion

In summary, this research addressed the question of whether parent-child attachment and parenting styles predicted parent's beliefs about the value of the use of play in therapy. This study revealed that parenting styles, specifically subscales within each parenting style, have an important role in determining whether parents value play in therapy. The findings showed the higher warmth and active involvement the parent reported, the more they valued the use of play in therapy. The more democratic the parent the less they valued the use of play in therapy. The more reasoning the parent was with their child, the more they valued the use of play in therapy. For parents who were in the permissive category the higher the parent-child attachment and the more self-confidence the more they valued the use of play in therapy. The less permissive parents followed through with consequences the less they valued the use of play in therapy. All parenting styles demonstrated that stronger the parent-child attachment the more the parent interacted with their child within their child's play. Children exposed to distressing or traumatic experiences learn how to be resilient primarily through secure attachment (Gaskill & Perry, 2014). These findings have important implications for future clinical practice to assist practitioners in understanding which parents they may need to

spend more time with in the beginning stages of the child's counselling to provide psycho-education on the important of play in working through traumatic experiences.

In conclusion, this research provides an important contribution to the limited research that exists on parent's attitudes toward the use of play in therapy for children impacted by trauma. It demonstrates that parent's willingness for their child to attend therapy does not make a difference to whether parents value the use of play. Rather, parenting styles and the qualities that make up each parenting style have an impact on parent's attitudes and beliefs toward the use of play in therapy. These findings can assist professionals to assess parental capacity for engagement when bringing their child to therapy, to better inform the practitioner how to coach parents regarding the value and use of play in therapy to help their child heal from trauma. Cohen, Mannarion and Rogel (2001) stated "Children who have experienced trauma lack the flexibility, fluidity and spontaneity normally found in children" (as cited in Myers, Bratton, Hagen & Findling, 2011, p. 68). To heal from the atrocity of relational trauma children need therapeutic approaches that foster healing through relationships; including the rebuilding of trust, experiencing safety and security, building confidence and mastery as well as reconnecting to love (Myers et al, 2011), play provides a vehicle for all of these essential experiences to take place.

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Appendices

Appendix A – Information Sheet

PARTICIPANT INFORMATION SHEET

An evaluation of parental/caregiver attitudes toward the use of play therapy for children impacted by trauma.

Invitation
You are invited to take part in a study that is investigating parental/caregiver attitudes toward the use of play in therapy for children impacted by trauma.

My name is Diane McGeachy and I am conducting this study as partial fulfillment of an Honours degree in Psychology at the University of Tasmania under the supervision of Dr Kimberley Norris. The researchers involved in this project are:

Dr Kimberley Norris
Position: Senior Lecturer
Division: Psychology

Diane McGeachy
Position: Honours Student
Division: Psychology

This information sheet outlines the purpose of the study and explains what would be involved if you choose to participate. Please feel free to contact the researchers should you have any unanswered questions after reading this information sheet.

What is the purpose of this study?
This study aims to investigate parental/caregiver attitudes toward the use of play in therapy for children impacted by trauma.

Why have I been invited to participate?
You have been invited to participate in this study because you are a parent/caregiver. You may or may not have a child who has experienced trauma. As a parent/caregiver who has a child who has experienced trauma you are faced with the important role of supporting your child to heal from their experience. Hearing from parents/caregivers about their experiences is often overlooked, yet is very important and can contribute to meaningful change in mental health services for children and their families.

What does this study involve?
Reading this information sheet, and should you wish to participate, going to the following web address https://surveys.utas.edu.au/index.php/546664?lang=en
The completion and submission of the online questionnaire package, which will be taken as consent to participate in this study.
It is estimated that completion of this study will take approximately 25-30 minutes of your time.

Are there any possible benefits from participation in this study?
You may benefit from taking the time to reflect on the questions asked in the questionnaire about your experiences, and what this has meant for you and your child/ren. This process may be beneficial for some parents/caregivers.

It is anticipated that the data from this study will provide benefit to the wider community in relation to evaluating parental/caregivers expectations for counselling with children who have experienced trauma and the impact this has on children accessing counselling. This research also aims to investigate whether play is perceived as a valuable way of supporting children to work through trauma.

Are there any possible risks from participation in this study?
Due to the sensitive nature of children who have experienced trauma, the online questionnaire package may raise some difficult feelings for you. If at any time you experience emotional or psychological discomfort, you are encouraged to stop answering the questions, and if needed, consider contacting a suitably qualified health professional. You may already have a mental health professional whom you see. If you do not, possible avenues to find a professional include seeing your GP for a referral to a Psychologist, accessing a Psychologist or Counsellor through your work EAP provider, contacting not for profit counselling organisations that offer counselling or phoning a help line e.g. Kids Helpline 1800 55 1800, beyondblue 1300 22 4636 or Lifeline 13 11 14.

All involvement in this study is confidential and no participants will be identified. All involvement with this study is voluntary and participants can decide not to participate or to stop participating at any time. Due to this study being anonymous any information provided regarding child abuse is confidential and the researchers are unable to make a report. If you would like to report concern for the welfare of a child, you can phone Child Safety Services Tasmania on 1300 737 639, or speak to your GP or your local support worker.

What if I change my mind during or after the study?
Participation in this study is entirely voluntary. You are able to withdraw from this study at any time and can do so without providing any explanation. Due to the anonymous nature of this study once you submit your online questionnaire there will be no way for the researchers to retrieve this information to remove it from the study. It is important to be sure you are comfortable with your responses being included in the data before you submit your responses online. Participants responses are anonymous.

What will happen to the information when this study is over?
Non-identifiable data from the self-report assessment and survey measures will be transferred to a statistical package to allow for data analysis and will be stored in secure cloud storage at the UTAS School of Medicine (Psychology) for five years following publication. Any printed paper records will be kept in a locked filing cabinet in the School of Psychology for five years following publication. After that time all electronic data will be erased and all paper records will be securely shredded. No identifying information will be used and the results from the study will be made freely available to all participants.

It is possible that research articles may also be written on the basis of information obtained through this study. Again, there will be no way of identifying you in any publication.

How will the results of the study be published?
Preliminary results from this study will be published on the University of Tasmania School of Medicine (Psychology) website in December 2017 (www.utas.edu.au/psychology). Participants will not be identifiable in the publication of the results. Participants can also

contact the researcher and request a copy of the study after the estimated completion in December 2017.

What if I have questions about this study?
If you have any questions about this study before or after you participate you can contact the researchers directly. Their contact details are below:

Dr Kimberley Norris
Phone: (03) 6226 7199
Email: Kimberley.Norris@utas.edu.au

Diane McGeachy
Phone: (03) 6226 7199
Email: dianem4@utas.edu.au

"This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on +61 3 6226 6254 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H0016485*

This information sheet is for participants to keep. If you consent to be involved in this study please go to the following web link to log in to the online survey https://surveys.utas.edu.au/index.php/546664?lang=en. Please note consent is implied by completion and submission of the survey.

Appendix B – Ethics Approval Letter

HUMAN RESEARCH ETHICS COMMITTEE
(TASMANIA) NETWORK

11 July 2017

Dr Kimberley Norris
Division of Psychology
University of Tasmania

Student Researcher: Laural Diane McGeachy

Sent via email

Dear Dr Norris

Re: FULL ETHICS APPLICATION APPROVAL Ethics Ref: **H0016485 - Parent and practitioner attitudes towards the use of play therapy for children who have been impacted by relational trauma**

We are pleased to advise that the Tasmania Social Sciences Human Research Ethics Committee approved the above project on 08 May 2017.

This approval constitutes ethical clearance by the Tasmania Social Sciences Human Research Ethics Committee. The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approval of other bodies or authorities is required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval.

1. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project.
2. Complaints: If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on

03 6226 7479 or human.ethics@utas.edu.au.

3. Incidents or adverse effects: Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.

5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**

6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely

Katherine Shaw

Executive Officer

Tasmania Social Sciences HREC

A PARTNERSHIP PROGRAM IN CONJUNCTION WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Appendix C – Parent Child Attachment Scale

Directions: How often would you say that...

	Often	**Sometimes**	**Seldom**	**Never**
1. You get along with your child?				
2. You feel that you can really trust your child?				
3. You just do not understand your child?				
4. Your child is too demanding?				
5. You really enjoy your child?				
6. Your child interferes with your activities?				
7. You think your child is terrific?				
8. You feel very angry toward your child?				
9. You feel violent toward your child?				
10. You feel proud of your child?				
11. You wish your child was more like others that you know?				

Appendix D – Parental Beliefs About Play Scale

This online survey is anonymous. It is greatly appreciated that you take your time to answer the questions honestly.

Directions: Please read each statement carefully and select your level of agreement of disagreement.

	Strongly Agree	**Agree**	**Neither Agree or Disagree**	**Disagree**	**Strongly Disagree**
1. Play can help my child develop better thinking abilities.					
2. Playing at home will help my child get ready for school.					
3. I teach my child social skills during play.					
4. If I take time to play with my child, s/he will be better at playing with others.					
5. Through play, my child develops new skills and abilities.					
6.Playing at school will help my child in primary school.					
7. Play helps my child learn to express his or her feelings.					
8. Play can improve my child's language and communication abilities.					
9. I can help my child learn to control his or her emotions during play.					
10. Play can help my child develop social skills.					
11. Playing together helps me build a good relationship with my child.					
12. Playing with my child is one of my favorite things to do.					

13. I have a lot of fun with my child when we play together.					
14. Play is a fun activity for my child.					
15. My child has a lot of fun when we play together.					
16. My child will get more out of play if I play with him or her.					
17. It is important for me to participate in play with my child.					
18. I do not think my child learns important skills by playing.					
19. Reading to my child is more worthwhile than playing with him or her.					
20. I would rather read to my child than play together.					
21. Playtime is not a high priority in my home.					
22. Play does not influence my child's ability to solve problems.					
23. It is more important for my child to have good academic skills than to play well with others.					
24. I do not think it is important for other family members to play with my child.					
25. Play does not help my child learn academic skills.					

Appendix E – Parenting Styles Dimension Questionnaire

Directions: Rate how often you do the following with your child

	Never	**Once in Awhile**	**About Half of the Time**	**Very Often**	**Always**
1. I encourage my child to talk about their troubles.					
2. I guide my child by punishment more than by reason.					
3. I know the names of my child's friends.					
4. I find it difficult to discipline my child.					
5. I give praise when my child is good.					
6. I spank when my child is disobedient.					
7. I joke and play with my child.					
8. I withhold scolding and/or criticism even when my child acts contrary to my wishes.					
9. I show sympathy when my child is hurt or frustrated.					
10. I punish by taking privileges away from my child with little if any explanations.					
11. I spoil my child.					
12. I give comfort and understanding when my child is upset.					
13. I yell or shout when my child misbehaves.					
14. I am easy going and relaxed with my child.					

15. I allow my child to annoy someone else.					
16. I tell my child my expectations regarding behavior before they engage in an activity.					
17. I scold and criticise to make my child improve.					
18. I show patience with my child.					
19. I grab my child when they are being disobedient.					
20. I state punishments to my child and do not actually do them.					
21. I am responsive to my child's feelings or needs.					
22. I allow my child to give input into family rules.					
23. I argue with my child.					
24. I appear confident about parenting abilities.					
25. I give my child reasons why rules should be obeyed.					
26. I appear to be more concerned with own feelings than with my child's feelings.					
27. I tell my child that I appreciate what they try or accomplishes.					
28. I punish by putting my child off somewhere alone with little if any explanations.					
29. I help my child to understand the impact of behavior by encouraging my child to talk about the consequences of his/her own actions.					
30. I am afraid that disciplining my child for misbehavior will cause my child to not like his/her parents.					

31. I take my child's desires into account before asking my child to do something.					
32. I explode in anger towards my child.					
33. I am aware of problems or concerns about my child in school.					
34. I threaten my child with punishment more often than actually giving it. 35. I express affection by hugging, kissing, and holding my child.					
36. I ignore my child's misbehavior.					
37. I use physical punishment as a way of disciplining my child.					
38. I carry out discipline after my child misbehaves.					
39. I apologise to my child when making a mistake in parenting.					
40. I tell my child what to do.					
41. I give into my child when my child causes a commotion about something.					
42. I talk it over and reason with my child when my child misbehaves.					
43. I slap my child when my child misbehaves.					
44. I disagree with my child.					
45. I allow my child to interrupt others.					
46. I have warm and intimate times together with my child.					
47. When two children are fighting, I discipline children first and asks questions later.					

48. I encourage my child to freely express (himself)(herself) even when disagreeing with parents.					
49. I bribe my child with rewards to bring about compliance.					
50. I scold or criticise when my child's behavior doesn't meet my expectations.					
51. I show respect for my child' s opinions by encouraging my child to express them.					
52. I set strict well-established rules for my child.					
53. I explain to my child how I feel about their good and bad behavior.					
54. I use threats as punishment with little or no justification.					
55. I take into account my child's preferences in making plans for the family.					
56. When my child asks why (he)(she) has to conform, I state: because I said so, or I am your parent and I want you to.					
57. I appear unsure on how to solve my child's misbehavior.					
58. I explain the consequences of my child's behavior.					
59. I demand that my child does/do things.					
60. I channel my child's misbehaviour into a more acceptable activity.					
61. I shove my child when my child is disobedient.					
62. I emphasise the reasons for rules.					

Appendix F – Attitudes Toward Seeking Professional Psychological Help- Short Form Scale

This online survey is anonymous. It is greatly appreciated that you take your time to answer the questions honestly. **Directions: Read each statement carefully and indicate you degree of agreement using the scale below. In responding, please be completely candid.**

	Disagree	**Partly Disagree**	**Partly Agree**	**Agree**
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.				
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.				
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.				
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.				
5. I would want to get psychological help if I were worried or upset for a long period of time.				
6. I might want to have psychological counselling in the future.				
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.				
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.				
9. A person should work out his or her own problems; psychological counselling would be a last resort.				
10. Personal and emotional troubles, like many things, tend to work out by themselves.				

Appendix G – Demographic information

This online survey is anonymous. It is greatly appreciated that you take your time to answer the questions honestly.

Sociodemographic Information

As you answer this survey, although you may have numerous children who have experienced trauma, please chose one of your children and answer all questions in this survey relating to this one child.

What is your gender?

Check any that apply
- Male
- Female
- Other

What is your ethnicity?

What is your occupation?

What is your relationship status?

Check any that apply
- Married
- Defacto
- Divorced
- Separated
- Single
- Widowed

What is your family income level?

Check any that apply
- 0 - $30,000
- $31,000 - $50,000
- $51,000 - $70,000
- $71,000 - $90,000
- $91,000 +

What is your relationship to your child?

Check any that apply
- Mother
- Father
- Caregiver

How many children do you have/care for?

Check any that apply
- 1
- 2
- 3
- 4
- 5 +

What is the age range of the child you are answering this survey about?

Check any that apply
- 0 - 2
- 3 - 5
- 6 - 8
- 9 - 12
- 13 - 18

Has your child ever experienced one or more of the following types of trauma?

Check any that apply
- Simple Trauma (one-time traumatic event such as natural disaster or car accident)
- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Witness to Family Violence
- Neglect

Has your child accessed counselling in relation to the trauma they experienced?

Check any that apply
- Yes
- No

Was there a fee per appointment for your child's counselling?

Check any that apply
- No
- Yes $10 - 30
- Yes $31 - $50
- Yes $51 - $80
- Yes $80 +

Appendix H – Parents Attitudes Towards Their Child's Counselling

Please answer the following questions about you and your child's experience of counselling relating to trauma.

	Strongly Disagree	**Neutral**	**Agree**	**Strongly Agree**
1. I had a positive experience of my child receiving counselling.				
2. I saw positive changes in my child while they attended counselling.				
3. These positive changes continued after my child stopped going to counselling.				
4. The therapist gave me feedback about my child's progress outside of counselling sessions.				
5. I was invited to participate in some of my child's counselling sessions.				
6. The therapist explained to me what they were doing with my child and the reasoning behind it.				
7. My child talked a lot with the therapist.				
8. My child mostly played with the therapist.				
9. I do not know what my child did in their counselling appointments.				
10. My child had fun and looked forward to going to counselling.				
11. My expectations of counselling matched what actually happened.				
12. I believe play can be used in counselling to help my child heal from trauma.				